Save the Children

Essential Services for Maternal and Child Survival in Ethiopia: Mobilizing the Traditional and Public Health Sectors and Informing Programming for Pastoralist Populations

Cooperative Agreement No. FAO-A-00-97-00054-00
September 30, 1997 - September 30, 2006

Ethiopia CS-17
First Annual Report

Prepared by

Tedbabe Degefie, MD
Health Specialist/Manager, SC Ethiopia Field Office

David Bourne
Acting DFOD, SC Ethiopia Field Office

Submitted to USAID/GH/HIDN
October 31, 2002

TABLE OF CONTENTS

ACRONYMS

ACNM	American College of Nurse Midwives
ANC	Ante-Natal Care
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BC	Behavior Change
BCC	Behavior Change Communication
BHR/FFP	Bureau of Humanitarian Response/Office of Food for Peace (USAID, now DCHA/FFP)
BHR/PVC	Bureau of Humanitarian Response/Office of Private and Voluntary Cooperation (USAID, now DCHA/PVC)
BHT	Bridge-to-Health Team
BSS	Behavioral Surveillance Survey
CAC	Community Action Committee
CBO	Community-Based Organization
CHA	Community Health Agent
CHW	Community Health Worker (BHT & HAC members, TBAs, CMWs, CBDs)
C-IMCI	Community-Integrated Management of Childhood Illness
CMW	Case Management Worker (CHW trained to do case management)
CS	Child Survival
CS-17	The current child survival project in Liben District, *Essential Services for Maternal and Child Survival in Ethiopia: Mobilizing the Traditional and Public Health Sectors and Informing Programming for Pastoralist Populations*, funded as a cost extension of the CS-13 grant, mainly through the 17th cycle of the PVO CS Grants Program, is referred to as "CS-17" throughout this document to distinguish it from the previous "CS-13" grant.
CSTS	Child Survival Technical Support Project (contractor to AID/DCHA/PVC)
DAC	District AIDS Council
DAP	Development Assistance Program (current FFP-funded Liben Title II program)
DFOD-MS	Deputy Field Office Director - Management Services
DHAC	District HIV/AIDS Council
DHMT	District Health Management Team
DHIMT	District Health Information Management Team
DHO	District Health Office/Officer
DIP	Detailed Implementation Plan
DKT	Ethiopian affiliate of PSI (Population Services International)
EFO	Ethiopia Field (Country) Office of Save the Children/US
EPI	

FGD	Expanded Program for Immunization
FHI	Focus Group Discussion
FO	Family Health International
FOD	Field Office
FMOH	Field Office Director
FP	Federal Ministry of Health
FY	Family Planning
GMP	Fiscal Year
HA	Growth Monitoring and Promotion
HAC	Health Assistant
HB-LSS	Health Action Committee
HF	Home-Based Life-Saving Skills
HH/C-IMCI	Health Facility
HIS	Household/Community Integrated Management of Childhood Illness
HIV	Health Information System
HIMS	Human Immune Deficiency Virus
HPN	Health Information Management System
HQ	Health, Population, and Nutrition
IACI	Headquarters
IEC	Integrated Approaches to Childhood Illness
IMCI	Information, Education, Communication
ISA	Integrated Management of Childhood Illness
Kebele	Institutional Strengths Assessment
Korra	Community consisting of several villages, but smaller than a PA
KPC	Elders' meeting
LQAS	Knowledge Practice and Coverage
LSS	Lot Quality Assurance Sampling
M&E	Life-Saving Skills (maternal and newborn)
MCH	Monitoring and Evaluation
MCM	Maternal and Child Health
MIS	Malaria Case Management
MN	Management Information Systems
MNC	Maternal and Newborn
MOH	Maternal and Newborn Care

MTE	Ministry of Health
NGO	Midterm Evaluation
NIDS	Non-Governmental Organization
Obba	National Immunization Days
OCA	Water points for cattle
OH	Organizational Capacity Assessment
ORT	Office of Health (of Save the Children/US)
OVC	Oral Rehydration Therapy
PA	Orphan and Vulnerable Children
PCM	Peasant Association ("kebele"), an administrative division
PHN	Pneumonia Case Management
PLI	Population, Health, and Nutrition
PLWHA	Pastoralist Livelihood Initiative
PM	People Living With HIV/AIDS
PVO	Program Manager
RH	Private Voluntary Organization
RHA	Reproductive Health
RHB	Reproductive Health Agent / Regional Health Advisor
SC/US	Regional Health Bureau (of the Ethiopian MOH)
SC/US/EFO	Save the Children Federation (USA)
SCM	Save the Children/US Ethiopia Field (Country) Office
SOS	Standard Case Management
SPA	Sustainable Outreach Service
STI	Senior Program Assistant (SC/US staff in Liben District)
TA	Sexually Transmitted Infection / Southern Tier Initiative (USAID/Ethiopia)
TBA	Technical Assistance
TOT	Traditional Birth Attendant
TT	Training of Trainers
TT2	Tetanus Toxoid
UNAIDS	Tetanus Toxoid, 2nd dose
Waaqeefatta	United Nations Program on HIV/AIDS
Woreda	Traditional followers of one God
ZHD	District
	Zonal Health Department

1. Introduction

Save the Children/US has been supporting two complementary programs throughout Liben District in Ethiopia since 1997; the CS project (CS-13 through September 2001, followed by CS-17), and a USAID/DCHA/FFP-funded DAP, which currently supports nutrition and breastfeeding interventions in the district, in addition to other development activities. The central strategy of SC/US health activities in Liben has been health promotion through 150 "Bridge-to-Health Teams" (BHTs), each composed of a wise woman/TBA, a wise man/male traditional healer, and a young traditional apprentice. Health Action Committees (HACs) review and respond to health information from BHTs and TBAs. Since April 2000, the American College of Nurse Midwives has been providing on-going technical support to improve obstetric care at community and health facility levels by training TBAs and health facility staff in Life Saving Skills.

CS-17 supports four interventions that were implemented under CS-13, including maternal and newborn care, pneumonia case management, control of malaria, and control of diarrheal disease, as well as two new interventions, support for immunization, funded until recently through the DAP, and HIV/AIDS.

These CS-17 interventions are implemented through the following major strategies:

- Joint DHO/SC/US design, implementation, and evaluation of approaches in maternal and child health in the Liben District that will inform the development of strategies to address the needs of pastoralist populations in other districts of Borana Zone and throughout Ethiopia.
- Continued mobilization of community leaders and traditional practitioners, through Bridge-to-Health Teams and Health Action Committees, to support selected MCH services, and to conduct focused education for the improvement of key emphasis behaviors at the household level.
- Introduction and evaluation of community-based case management of childhood illness to improve access to and use of these services in Liben District, and to inform the nascent development of Community-IMCI in Ethiopia.
- Capacity building of SC/US, the DHO, and the district HIV/AIDS council to provide leadership, coordination, and technical advice for integration of effective HIV prevention, care and support, and mitigation efforts into ongoing community and government activities in Liben District.

This annual report (FY2002) describes the responses to the DIP review, preliminary results of the BSS, CS-17 project accomplishments, and the constraints encountered and actions taken during implementation.

2. Program Goals and Objectives

The overall program goals are:

- A sustained reduction in under-five and maternal mortality in Liben District
- CS-17 approaches inform policy or programming for pastoralist areas of Ethiopia in Community-IMCI or reproductive health

These goals will be achieved through:

- Improved district capacity to effectively support community health services and activities
- Improved community capacity to effectively address priority health needs of mothers and children under five
- Increased use of key health services and improved MCH practices at household level
- Adoption of CS-17 approaches by the MOH or by other organizations in Ethiopia

3. Response to the DIP Review

a) *How the program will address the urban/peri-urban vs. rural target population and any strategies to be tailored and implemented in order to reach the different groups.*

The program will use different channels and forums of communication to address the target population in urban/peri-urban and in rural communities. For example, community agents in rural areas reach the community at water points and rally posts, and in urban/peri-urban areas use interpersonal communication and posters and flip charts in addition to video dramas, anti-AIDS club member activities, and printed health messages. The health delivery system in urban areas is static while in rural areas health services are often mobile. In addition, the program will assess the target audience's perception and understanding of health messages and refine the messages accordingly.

b) *Any examples of data sharing with targeted communities*

BHTs and HACs get feedback from the SPAs in monthly and quarterly meetings where the review of plans and achievements is conducted. EPI coverage for the PA and follow up on defaulters is ongoing. For example, if there is a disease outbreak from vaccine preventable diseases then the information is shared with HAC and BHT members. The program will strengthen information sharing with the community at large and ensure that the community receives the data analysis from the DHIMT.

c) *How the program may build IEC/BCC into the minimum standards for quality of care including assessment of BCC materials and supervisory checklists*

The program has already included the supply of IEC/BCC materials in the supervisory checklists. Additional materials will be development to address IMCI key behavior/practice. The materials will be developed in line with the national C/HH-IMCI strategy, which is being defined according to the baseline data collected in northern Ethiopia where the National IMCI task force will pilot C/HH-IMCI. However, CS-17 will identify appropriate strategies and messages relevant to the communities living in Liben District.

d) *Whether men are to be targeted in the program's BCC and HIV/AIDS strategies and how the program will do this*

Men are targeted in all IEC/BCC messages. Although few men attend the rally posts, they gather at water points for cattle ("Obba"), and attend elders meetings ("Korra") and Kebele meetings. The community health workers use these gatherings as one channel of communication. In the case of family planning messages the CHWs use individual interpersonal communication during house visits. There is a need for more information regarding men's attitudes, beliefs, perceptions, and perceived needs. KPCs usually target mothers leaving an information gap among men. The program will conduct such an assessment before designing the messages.

e) *Condom supply situation for the program*

NGO Network's support of FP activities in the district and DKT's social marketing are the main sources of condom supply at present. Community based distributors; health facilities, shops and pharmacies are the outlets for the distribution. Networks funding is phasing out and SC/US is looking for other sources of funding to continue the supply. However, the program will continue IEC/BCC work to increase the demand and utilization of condoms supplied though social marketing.

f) *Clarify the M&E plan with information on what, how and who will collect the data (identified in the M&E matrix)*

Please see Annex 4.

g) *Discuss any objectives and indicators that are similar and relevant to the DAP*

Results of CS-17 activities include increased use of key health services, and improved MCH practices at the household level. These are also addressed through complementary human health interventions in the DAP. Indicators relevant for the DAP are:

- % of births attended by trained TBA or health professional
- % of all mothers of children <2 receiving TT2+ before last child's birth
- 25% of all 12-23 month olds fully immunized

The PLI will integrate the use of Title II food commodities through a new approved DAP, with DA funds, to address three Strategic Objectives:

1. Improved health and nutritional status among women and children in the target area;

2. Improved natural resource management by pastoralists in the target areas; and

3. Increased pastoralist income and income/asset diversification in target areas.

Communities will be mobilized and empowered to build decision-making and technical skills through Community Action Committees (CACs), and through health, water, and natural resource management committees. As part of the PLI sustainability plan, targeted groups will develop community-managed savings plans that will make resources available to continue priority development activities after the five year PLI program has ended. CACs will function as a coordinating body for all technical committees trained by SC/US that function in the community to facilitate change and skills development for pastoralist families/individuals.

Resources such as training materials and technical assistance will be shared to build synergy between the PLI and CS-17. Outside of Liben District, the new DA/DAP program plans to implement a variety of human health activities based on CS-13 and CS-17 strategies and experiences. In Liben District, the PLI will complement CS-17, focusing on nutrition and breastfeeding interventions. In nutrition the PLI plans to pilot growth promotion activities. In each PA, two BHT members will be trained to organize and facilitate GMP sessions with support from SC/US staff.

A similar pilot approach is planned for establishing breastfeeding support groups. Lactating mothers participating in the GMP activities, who have children that are faltering in weight gain, will be encouraged to join support groups for breastfeeding. Following GMP sessions these mothers will meet every month for about 60 minutes to share breastfeeding experiences and problems and to explore alternative solutions with other mothers from their own villages. TBAs and BHT members will facilitate these meetings. In time, mothers who have had successful breastfeeding experiences will be identified to lead future meetings. In addition, other communication channels will be used to promote improved nutrition practices. Along with nutrition education by BHTs, HACs, and MOH staff, opportunities for public campaigns will be identified, such as market days and festivals.

h) *Issues of Orphans and Vulnerable Children, especially with regard to the HIV/AIDS intervention*

Through the newly introduced HIV/AIDS intervention, the Orphans and Vulnerable Children (OVC) issue is given emphasis in the context of supporting the district HIV/AIDS council activities, and addressing the issue of stigma through appropriate messages and channels. The program will build the capacity of community based organizations so that they are able to protect vulnerable children. In addition, SC/US and Save the Children Alliance partners in Ethiopia have proposed a three-year project for improving the protection of orphans and vulnerable children affected by HIV/AIDS in Ethiopia. The proposed "Protection for OVC Affected by HIV/AIDS Project" will promote the development of HIV/AIDS prevention, care and support programs through advocacy for OVC protection and capacity building of caregivers to reduce the risk and impacts of HIV infection. The project sites selected for the implementation of this project are SC/US and Alliance project areas. In the first year implementation will be carried out by SC/US in Addis Ababa and Liben Impact Areas. Currently, with some financial support from all Alliance members, start-up activities have begun. SC/US hired

two Orphan and Vulnerable Children Officers who are carrying out the following activities:

1. With local community groups, conduct an assessment of local mechanisms and available services for OVC.
2. Conduct workshops for communities to disseminate information regarding policy and best practices, initiate discussion on the implementation of the OVC protection project, and make overview copies available to implementers.
3. Work with the community to set criteria for the identification of orphans and vulnerable children in the community.
4. Strengthen capacity to render support to orphans and vulnerable children and monitor and evaluate progress.

i) *Explore ways of collaborating, communicating, and/or sharing information with other CS programs in Ethiopia*

World Vision International has phased out of CS activities, while CARE is going to implement in the northern part of the country. Africare implements CS activities in Gambella. The program will use workshops and different meetings to share CS experiences. The program also will explore experience-sharing exchange opportunities among program staff.

4. Accomplishments

At a joint planning session, the detailed implementation plan was formulated and the final draft shared with the partners and the district health office. All activities are on track with the exception of the startup of community IMCI. EPI coverage shows improvement as a result of the implementation of SOS to deliver vaccination and ANC to remote and inaccessible PAs, and due to intensive mobilization by the CHWs. The sustainability of this level of coverage is a challenge as resource allocation for EPI remains inadequate and the service currently relies on the program's logistic support. The newly introduced HIV/AIDS intervention is gaining momentum. The BSS is completed and has identified that there is low level of knowledge about HIV/AIDS, misconception and stigma exists and people do not recognize personal risk or protect themselves. The intervention is very vital and will use research findings to adjust activities. Component one of IMCI is just beginning to reach the Oromia region and the national IMCI task force advised that SC/US seek the mandate of FMOH before piloting PCM. HH/C-IMCI is going to be piloted in two regions in the north of the country. The baseline survey has just been completed and it is expected that the national strategy for HH/C-IMCI will be drafted from the finding of the survey. SC/US has continued dialogue to get the permission for piloting PCM. The project's main accomplishments are as follows:

a. Organizational Capacity Assessment (OCA)

SC/US has contracted PACT to do the organizational capacity assessment. The assessment includes the FO, the ARSH program, the Child Survival impact area, the district health office, and SC/US refugee programs in Jigjiga. The assessment is expected to provide information on organizational strengths and weakness as well as develop the skills of SC/US staff members to utilize the OCA and to analyze the results to enhance organizational development.

b. Behavioral Surveillance Survey (BSS)

Family Health International (FHI) and UNICEF, with local partners including SC/US, completed a nation-wide first of its kind HIV behavioral surveillance survey (BSS). In Liben District, the target groups selected were in school and out of school youth, commercial sex workers, and pastoralist community members. The preliminary result of the survey showed few encouraging and some grave results. Not surprisingly, the knowledge of preventive methods increases with the number of media sources for HIV/AIDS messages. The majority of respondents have awareness about HIV/AIDS. However nearly two out of three young people out of school reported that they were sexually active and had sex with two or more partners in the last year. In some areas, sexually active out of school girls are even more likely than boys to report multiple partners. Condom accessibility and cost are not barriers to condom use among most groups, and condom use is high among commercial sex workers. But significant proportions of respondents do not always use condoms with non-regular partners, though they know it protects them from HIV/AIDS. A little more than one-in-five of married respondents have had multiple partners in the last twelve months, and more than 60 percent of the married respondents who have had multiple partners in the last twelve months did not always use a condom. In summary the result shows that:

- About 98% of study population is aware of HIV/AIDS.
- Almost all groups know at least one preventive method.
- Nearly 60% know all three prevention methods.
- Commercial sex is more common among mobile men with money.
- Non-commercial sex is relatively very high among in and out of school youth.
- Misconception about HIV/AIDS transmission remains high in almost all groups and regions.
- Misconception about HIV/AIDS is high irrespective of the level of knowledge.
- Own risk perception is very low in almost all target groups.
- Most of the respondents who had unprotected sex with non-marital partners do not feel they are at risk.

A qualitative study is being conducted to further identify current beliefs and attitudes. Focus group discussions are being conducted and the results are expected to be ready by the end of this year. For a summary of the results in Liben see Annex 3.

Key indicators that are being tracked are those that define aspects of behavior important to the spread of HIV, the same behaviors that HIV prevention programs generally try to change.[1] Tracking of these indicators over time will provide a way to track changes in these behaviors over time.

c. Training

The software database developed through the CS-13 grant has been installed and the necessary training provided for relevant program and DHO staff. This software is believed to build the DHMT's capacity and strengthen the district's HIMS capacity to timely, collect, analyze and synthesize information as a tool for informed health problem decision-making.

In addition, the district HIV/AIDS council members and subcommittee were trained in program design and management. As a result the district HIV/AIDS council and Kebele sub-committee developed a proposal and secured the first round of a World Bank loan for the Ethiopian government. The first round of activities are focused on awareness raising. The subsequent grant will include care and support for PLWHA.

5. Technical Assistance Needs

CS-17 is receiving assistance with formative research to develop behavior change strategies and materials, particularly for the STI/HIV/AIDS intervention, and for the development of training materials and curricula for trainers of community groups, sex workers, and health workers in STI/HIV/AIDS interpersonal communication, peer education, and counseling. Much of this TA is being provided by the EFO's new Behavior Change Officer based in Addis Ababa.

TA for further development and expansion of LSS activities is continuing through the American College of Nurse Midwives (ACNM).

CARE/Kenya has provided TA to CS-13/-17 in the form of algorithms and training materials for case management of childhood pneumonia, malaria, and diarrhea at the community level. SC and MOH staff plan to visit CARE's Siaya project site in December 2002 to learn more from CARE's experience implementing community-based case management.

SC staff believe that it may be very beneficial for CS-18 to monitor caretaker knowledge and practices in SPA/health facility jurisdictions, and use this information to improve performance in weaker areas. SC is thus working with NGO Networks for Health staff to schedule LQAS training for EFO/CS-17 staff.

[1] MEASURE Evaluation/ UNAIDS/ WHO guide to monitoring and evaluation of National AIDS Programs.

6. Changes in the Approved Agreement

There was no substantial change from the program description and the DIP. There was no modification required to the Cooperative Agreement.

7. CS-17 Devolution / Phase-Out Strategy

While embracing the community-based approach to capacity building and the phasing out SC/US support for CS-17 community-level activities, SC/US does not believe that it is realistic to hope for a health system in Liben in the near future that is capable of reaching the majority of the population with quality essential MCH services without substantial external inputs. Until the Government of Ethiopia demonstrates the will and resources to adequately support the provision of health services to poor and marginalized communities in Borana Zone, external support will remain necessary to ensure that lives are not lost unnecessarily and that people are afforded access to basic health services. However, SC/US's strategy in Liben does involve the gradual transition and reduction of external inputs required to maintain support for essential community health services and activities.

Since 1992, the Government has taken steps not only to increase the over all share of health in the budget but also to reallocate resources away from urban hospital-based curative services toward more preventive care emphasizing the rural population. Despite such measures, the sector suffers from chronic undefunding and external support remains an essential aspect of the health care financing.

Prospects for other external support: In addition to receiving support from the DAP/DA Food Security funding pool, Liben District is currently included in USAID's "Southern Tier Initiative—Special Objective" (STI) catchment area. A primary component of the STI is maternal and child health, and thus, funding prospects for further strengthening core activities appear good.

8. Management Systems

SC/US's management strategy for CS-17 has been significantly modeled by past experience and the recommendations of the CS-13 and DAP final evaluations. These reports cited the need for increased technical support both in Negelle and from Addis Ababa and a greater level of senior management involvement in program implementation. The key features of our management strategy are:

- An internal and external teaming strategy that brings in-depth knowledge of maternal and child health, Liben District, and extensive Ethiopia-based experience implementing culturally appropriate programs in cooperation with the MOH and communities.
- Key operational partnerships that maximize resources and project impacts.
- A lean organizational configuration with a clear division of functions and a single line-management structure.

- A support structure in Addis Ababa and the United States staffed with personnel experienced in community mobilization, maternal and child health, and HIV/AIDS.
- A commitment to transparent processes involving frequent dialogue with colleagues and partners.

CS-17 seeks to promote program ownership and prospects for sustainability at the DHO, health facility, and community levels through its approach to program management. The new management structure will increase DHO staff roles in CS project management, as well as ownership of project activities and results.[1] However due to the decentralization process going on in the country in general and specifically in the district, the DHO has not assumed its role in program ownership. The program will maintain dialogue and support until the new role of the DHO is well defined and it shoulders the required responsibilities.

a. Financial Management

The SC/US Ethiopia Field Office (EFO) is responsible for all financial transactions and budget control, and has a strong financial management system in place that utilizes Sun Systems software. The SC/US Home Office conducts monthly financial review and monitoring in collaboration with the EFO finance unit. The EFO has clear written procedures for disbursement and accounting of financial transactions. There is also a clear line of authority for financial payments. The CS-17 program coordinator can only authorize payments up to $250 and the program manager up to $6,250. Amounts above $6,250 need to be authorized by the FOD.

Project staff submits monthly budget requests based on planned activities and receive advances from the EFO to support implementation. The Liben impact area has a computerized system for tracking all expenditures on a monthly basis. All requests for funds are based on activity registration, which must be completed at least one month before the advance request is submitted. Monthly financial reports are submitted to the EFO finance unit, where reports from all impact areas are finalized and sent to Westport. The EFO's finance unit in Addis Ababa conducts budget monitoring monthly. Copies of the monthly budget summaries are provided to the impact area program manger. The M&E Unit has the responsibility of crosschecking that the registered activity is completed before more money is disbursed for a similar or subsequent activity by the sector.

The DHO is involved in CS-17 project planning, management, and routine implementation. The DHMT will oversee and plan activities, and will include enough permanent staff to ensure that district capacity is maintained, even when staff turnover occurs. The DHMT will have quarterly review and planning meetings, and budgeting and monitoring meetings with the Liben Program Manager.

[1] Compared to the CS-13 project management structure.

b. Human Resources

The Program Operations Director at the FO level, who has recently been promoted from the Negelle Program Manager position (where he had oversight responsibility for CS-13 and CS-17 activities) will provide oversight for program implementation. A new PM has been recruited and is based in the impact area. In addition, the Health Advisor post is also filled. The field based Program Manager reports to the Programs Operations Director (POD) who in turn works closely with, and reports to, the expatriate Deputy Field Office Director for Programs (DFOD). The POD and DFOD ensure that project activities are carried out per the project agreement, and that timely and accurate reporting is conducted. Both the POD and the DFOD travel periodically to Liben to meet with project staff, discuss concerns and constraints, and to find solutions to these problems. Regular staff meetings including the PM and project technical staff are conducted in Liben. The Addis Ababa-bsaed Health Specialist also provides technical support and oversight for all health activities.

c. Communication System

The SC/US office in Addis Ababa provides procurement and human resource management support and ensures that all SC/US polices and procedures are observed at all levels of field office operations.

The communication between the EFO in Addis Ababa and the Liben office has been improved by e-mail access. However this access is at the moment limited to one line and is expected to improve in the near future when the Telecommunication service for the District is upgraded.

d. Relationships with Local Partners

SC/US works closely with the DHO in all CS-17 activities. Joint coordination meetings are held quarterly, and a joint supervision exercise is conducted biannually of all health facilities in the district. SC/US maintains a very strong and constructive working relationship with the DHO and with the zonal Health Bureau also located in Negelle. Through BHTs and HACs SC/US also works closely with communities to ensure that their expressed needs are incorporated into program planning and response.

e. PVO Coordination and Collaboration

SC/US has a close relationship with other PVO implementing Child Survival programs in Ethiopia. World Vision International has phased out of CS activities, while CARE is going to implement in the northern part of the country. Africare focuses CS activities in Gambella. The program will use workshops and different meetings to share CS experiences. The program also will explore experience-sharing exchange opportunities among program staff. There is a discussion with CARE Ethiopia to coordinate experience sharing visit to CARE Kenya.

f. Recent Office of Health Activities Related to Issues Prioritized in the February/March 2002 Institutional Strengths Assessment of SC's Home Office Backstopping of CS Grants

1. Field training/clarification regarding budget line-item flexibility; and training and providing on- or off-the-books activity costing for program managers: These activities were recently conducted by SC Finance and Grants Management staff in Ethiopia for SC's Ethiopia Field Office staff, and are planned for November 2002 and May 2003 for SC Middle-East/Eurasia and Africa area staff.
2. Further develop BCC support capacity by adding a Behavior Change Communication Specialist: Karin Lapping has been hired by SC's Office of Health (OH) in the position of "Positive Deviance and Behavior Change Coordinator" on a part-time basis.
3. Diversify donor base & increase resource mobilization: OH is seeking funding from sources other than USAID/GH/HIDN (which now houses the PVO Child Survival and Health Grants Program) to support OH MCH-related initiatives for immunization; community case management of childhood malaria, pneumonia, and diarrhea; and safe motherhood.
4. Train field staff in & implement capacity assessments at field level: This is now being done with regard to SC's three CS-18 grants in Guinea, Tajikistan, and Viet Nam.
5. Further development and implementation of a Quality Assurance program: This is on the agenda of SC's agency-wide Planning, Monitoring, and Evaluation Working Group.
6. A more systematic approach to building field capacity in management, leadership, and technical and crosscutting (M&E, research, training, etc.) skills and knowledge: OH conducted a week-long training workshop in program planning, monitoring, and evaluation in Bangkok in July 2002 for Asia-area senior SC health program managers. A similar workshop is planned for the near future for Africa-area staff.

Annex 1

CS-17 Detailed Work Plan for the Second Year of the Project

Activity	Month											
	10	11	12	1	2	3	4	5	6	7	8	9
1. Expanded Program on Immunization (EPI)												
1.1. Support ongoing DHO immunization activities	v	v	v	v	v	v	v	v	v	v	v	v
1.2 Supply cold chain equipment to 2 health facilities	v											
1.3. Print EPI cards	v											
2. HIV/AIDS/STI												
2.1. Awareness raising												
2.1.1. Health Education at HF, outreach sites and community gatherings in integrated manner with other activities	v	v	v	v	v	v	v	v	v	v	v	v
2.1.2. Incorporating HIV/AIDS/STI topics in all training curriculums and a minimum set of HIV/AIDS/STI topics in SC/DAP staff training	v											
2.2. HIV/AIDS/STI vulnerability reduction												
2.2.1 Promotion of condom utilization through BCC	v	v	v	v	v	v	v	v	v	v	v	v
2.2.2. Enhancing safe obstetric practice by teaching TBAs and mothers emphasizing birth planning and supply of gloves through FP intervention	v	v	v	v	v	v	v	v	v	v	v	v
2.3. Capacity Building												
2.3.1. Build HIV BCC capacity and support District HIV/AIDS Council	v	v	v	v	v	v	v	v	v	v	v	v
2.3.2 Support CBO & Anti-AIDS club, including training	v	v	v	v	v	v	v	v	v	v	v	v
2.3.3 IEC materials production/Adaptation	v											
3. Maternal & Newborn Care												
3.1 MOH ANC support at static and outreach sites, follow up support and supervision of TBAs	v	v	v	v	v	v	v	v	v	v	v	v
3.2 IEC materials production	v											
4. Training												
4.1 CBO training on home-based care and support on HIV/AIDS		v	v	v	v	v	v	v	v	v	v	v
4.2 Peer educators training				v								
4.3 MOH staff training on STI syndromic management & counseling		v										
4.4 Non-formal basic education facilitators training on HIV/AIDS			v									
5. Maternal & Newborn care												
5.1 HB-LSS training for HACs & BHTs					v							
5.2 HB-LSS training for TBAs		v										
5.3 Community Midwives training	v	v	v	v	v	v						
6. Community Based Case Management												
6.1 Training of health facility staff in PCM/MCM/CDD			v									
6.2 CHWs case management training				v								

Annex 2

CS-17 Planed Activities and Accomplishments in FY 02

Program category	Accomplishments (% of target achieved)	Constraints	Actions Taken	Remarks
Human Resource: Program Manger Health advisor BCC specialist Procurement & Supply DIP preparation	 hired hired hired accomplished accomplished			3SPAs are not hired because of Shortage of qualified staff in the area
Training: -Peer Educators and CBO -HIV/AIDS sub-committee and District HIV/AIDS council -BHT & HAC on HIV/AIDS/STI -CBO training on home based care & support -TOT for MOH staff on HBLSS -LSS training for DHO and HF staff -HBLSS orientation for HAC & BHT -EPI refresher for HAC & BHT -Modular training for MOH staff & SPAs -incorporate HIV/AIDS/STI topics in all training curricula -Design PMC/MCM/CDD curricula	 100% >100% 100% accomplished 100% 4/12 100% 100% accomplished accomplished not accomplished	Only four Midwives are present at the hospital The Zonal/District Offices has not give the permission for SC to start the pilot although the permission is available from the regional level. The National IMCI task	SC has continued dialogue with the National IMCI task force. The head of the task force and other policy makers from the FMOH and project staff will visit	Plan was to train only the District HIV/AIDS council but later on it was necessary to train the sub committee as well and it could be done with DA funds SC will visit CARE's project site in Siaya with members of IMCI task force

-Revise previous BHT & HAC training curricula Trainings pertaining to IMCI	Accomplished Not accomplished	force advised SC to concur with the national action plan Late budget release, IMCI has is just began in Oromia region.	CARE's CS program in Northern Kenya in December 02 Trainings will be given in FY03	
Technical Assistance	From SC's headquarters CS Specialist provided TA in the DIP designing ACNM provided TA in HBLSS training for TBA, TOT for master trainers in Negele hospital and clinics.			
EPI Logistic support is ongoing to the District Health Office Modular training on EPI	Immunization coverage in under 1 year old infants 132%, pregnant women 104% and women of child bearing age 93% Accomplished 86%	The DHO relies on the program's logistic support. The only car and motorbike is non-functional	SC maintains dialogue and discussion with the DHO, introduced new pilot strategies-SOS to reach the difficult to reach places, the DHO will be increasingly involved in the management of CS-17.	
Maternal and Newborn care Ongoing support for the DHO to conduct out reach ANC	96% First ANC visit to HF 113% accomplished			

Annex 3

BSS Preliminary Results

Table1. Male and female Pastoralist (15-49 years) in Borena, August 2002

Indicator	Male #(%)	Female #(%)	Total #(%)
Knowledge of HIV preventive methods	73(20.9)	99(28)	172(24.5)
No incorrect Beliefs about AIDS	130(37.1)	75(21.2)	205(29.2)
Comprehensive knowledge about AIDS	41(11.7)	32(9.1)	73(10.4)
Accepting Attitudes towards those infected by HIV/AIDS	16(4.6)	10(2.8)	26(3.7)
Mean age at first sex	18.6	16.2	
Non-regular sex in the last 12 months	46(14.4)	25(7.7)	71(11)
Condom use at last non-regular sex	2(4.3)	1(4.0)	3(4.2)
Commercial sex among young men in the last 12 months	2(4.3)	-	-

Table 2. Major indicators by Sex for Pastoralists,

Indicator	Male		Female		Total	
	#	%	#	%	#	%
Knowledge Questions						
Can people protect themselves from HIV, the virus that causes AIDS by using a condom correctly every time they have sex? (Yes)	88	25.1	111	31.4	199	28.3
Can people protect themselves from HIV by abstaining from sexual intercourse? (Yes)	277	79.1	297	84.1	574	81.7
Can people protect themselves from HIV by having one uninfected faithful sex partner? (Yes)	283	80.9	290	82.2	573	81.5
No Misconceptions						
Can a person get the HIV virus from mosquito bites? (No)	181	51.7	141	39.9	322	45.8
Can a person get HIV by sharing a meal with someone who is infected? (No)	203	58.0	184	52.1	387	55.0
Do you think a healthy looking person can be infected with HIV, the virus that causes AIDS (Yes)	293	83.7	208	58.9	501	71.3
Attitude questions						
Would you be willing to share a meal with a person you knew had HIV or AIDS? (Yes)	38	10.9	40	11.3	78	11.1
If a male relative of yours became ill With HIV, the virus that causes AIDS, would you be willing to care for him in your household? (Yes)	306	87.4	123	34.8	429	61.0
If a female relative of yours became ill With HIV, the virus that causes AIDS, would you be willing to care for him in your household? (Yes)	297	84.9	122	34.6	419	59.6
If a Borena youth (Game, Kusa, or Raba) Has HIV but is not sick, should he or she Be allowed to continue to participate in "looking after the cattle or Nyachisa"-ritual performed by Borena youth? (Yes)	88	25.1	113	32.0	201	28.6
If abba gada or adula of Borena has HIV but is not sick, should he be allowed to continue to perform gada rituals? (Yes)	104	29.7	113	32.0	217	30.9
If a member of your family became ill with HIV, the virus that causes AIDS, would you want it to remain secret? (No)	324	92.6	331	93.8	655	93.2

Annex 4

CS-17 Revised M&E Matrix According to the DIP Review

CS-17 Capacity Building Results, Indicators/Sources, Measurement Methods, Data Collectors, Baseline Values, and End of Project Targets by Intervention

Result / IR	#	Indicator [indicator source]	Method	Who	Basel.	Target	Interv.
R-1: Improved **Liben District capacity** to effectively support community health services & activities.	1	District Health Management Team has met 3 or more times in last year & has used data to plan activities.[(1)]	Minutes MTE & FE	DHMT & Eval. teams	No	By MTE & FE	All
	2	District HIV/AIDS Council meets regularly, plans, & monitors HIV/AIDS activities in Liben.	Final evaluation	Final eval. team	No	Yes	HIV
	3a	% of PAs from which three or more HAC members have participated in three or more meetings with MOH staff over the previous year.[(1)]	Health facility records	SPAs & HAs	NA	80%	All
R-2: Improved **community capacity** in Liben to effectively address priority health needs of mothers & children under 5.	3b	% of PAs from which three or more HAC members have participated in three or more meetings with MOH staff over the previous year.[(1)]	Health facility records	SPAs & HAs	NA	80%	All
	4	% of CMWs trained in pneumonia case management with no stock-out of cotrimoxazole in the previous month.	CMW survey	Eval. teams	NA	80%	ARI
	5	% of CMWs trained in malaria or pneumonia case management through CS-17 from whom reports were received in past quarter.	Health facility records	SPAs & HAs	NA	80%	ARI Mal.
	6	% of BHTs which in the last 6 months have conducted 1 or more community education activity for each CS-17 intervention & turned in 4 or more monthly reports to HACs.[(1)]	BHT forms at health facilities	BHTs & HACs	NA	80%	All
	7	% of HACs which in the last 6 months have reviewed BHT, TBA, or CMW reports, & have sent reports to health facility.[(1)]	BHT forms at health facilities	HACs	NA	80%	All
IR-5: Increased **SC Addis & Liben capacity** in behavior change & integrated HIV programming.	8	EFO Behavior Change Specialist hired and retained.	MTE & FE	Eval. teams	No	Oct. 2002	All
	9	BC strategy for all CS-17 interventions designed & implementation started.	MTE & FE	Eval. teams	No	March 2003	All
	10	HIV prevention efforts effectively integrated into ongoing community & government activities through CS-17.	MTE & FE	Eval. teams	No	Yes	HIV
	11	Number of HIV-related training courses, workshops, & experience sharing visits in which SC/Liben staff have participated during CS-17.	CS-17 records	Eval. teams	0	5	HIV

Indicator sources: **1**: CS-13; **2**: Current DAP; **3**: KPC 2000+ CATCH / KPC 2000+; ( ) indicator modified.

CS-17 Results and Indicators Related to Use of Health Services and Health Practices
Measurement Methods, Data Collectors, Baseline Values, and End of Project Targets

Result / IR	#	Indicator [indicator source]	Method	Who	Basel.	Target	Interv.
R-3: Increased **use** of key health services and improved MCH **practices** at household level in Liben District.	12	Total rate of treatment for pneumonia in <5s by CMWs in all PAs with CMWs trained in PCM (number of treatments per <5 per year).	CMW Records	CMWs	NA	0.2 [i]	ARI
	13	% of respondents reporting condom use last time they had sex with non-regular partner.[ii]	FHI survey	FHI surveyors	4%	30%	HIV
	14	% of respondents reporting condom use every time they had sex with any non-regular partner over past 12 months.[iii]	FHI survey	FHI surveyors	Data from FHI soon	20%	HIV
	15	% of births attended by trained TBA or health professional.[1,2]	KPC	KPC surveyors	36%	50%	MNC
	16	% of all mothers of children <2 receiving TT2+ before last child's birth (card).[2,3]	KPC	KPC surveyors	21%	50%	EPI
	17	% of pregnant women receiving TT2+.	DHO	HF/DHO staff	26%	55%	EPI
	18	% of all 12-23 month olds who received measles immunization (by card only).[2,3]	KPC	KPC surveyors	32%	60%	EPI
	19	% of infants who received measles immunization.	DHO	HF/DHO staff	43%	70%	EPI
	20	25% of all 12-23 month olds fully immunized (by card).[2,(3)]	KPC	KPC surveyors	19%	40%	EPI
	21	25% of infants fully immunized.	DHO	HF/DHO	34%	60%	EPI
	22	% of children <2 with diarrhea in the past 2 weeks receiving more fluids than usual & same or more food than usual during illness.[(3)]	KPC	KPC surveyors	8%	50%	CDD
(#33: New objective added in First Annual Report, Sep. 2002, in response to DIP review.)	33	% of mothers with children <24 months who report washing own hands with soap or ash before food prep., before feeding children, after defecation, & after attending child who defecated.[3]	KPC	KPC surveyors	NA	25%	CDD

Indicator sources: **1**: CS-13; **2**: Current DAP; **3**: KPC 2000+ CATCH / KPC 2000+; ( ) indicator modified.

CS-17 Results and Indicators Related to Uptake, Availability, Quality, and Knowledge
Measurement Methods, Data Collectors, Baseline Values, and End of Project Targets by Intervention

Result / IR	#	Indicator [indicator source]	Method	Who	Basel.	Target	Interv.
R-4: Uptake/ Sustainability: Adoption of CS-17 approach by MOH or by other organization.	23	MOH or other PVO/NGO in other district of Ethiopia has written plans for implementation of CS-17 approach to C-IMCI, MN/LSS, or BHTs.	Reports of MOH or other orgs.	SC EFO staff	No	Yes	All
IR-4: Dissemination of feasibility & results of implementing innovative CS-17 approaches.	24	Feasibility & results of implementing CB-ARI/Mal. case management, MN/LSS, and/or BHTs, through CS-17, presented at conference(s), in publication, through media, and/or site visit.	CS-17 reports, & final eval.	Final eval. team	NA	Yes	ARI MNC
IR-1: Increased **availability** of select MCH services in Liben.	25	% of rural PAs which have an MOH facility or CMW(s) trained through CS-17 in ARI or malaria case management.	CS-17 Records	CS-17 staff	19%	100%	ARI Mal.
	26	% of rural PAs with TBAs trained in HB-LSS.[(1)]	"	CS-17 staff	36%	100%	MNC
IR-2: Documented **quality** of select community MCH services in Liben District.	27	% of children under five assessed for pneumonia for which CMW reported completing all PCM steps correctly.	CMW report to superv.	SPAs HAs	NA	80%	ARI
	28	% of mothers/newborns with complications for which TBAs reported completing all HB-LSS steps correctly.	HB-LSS tracking form	SPAs HAs	NA	50%	MNC
IR-3: Increased maternal **knowledge** in Liben District of selected MCH issues.	29	% of mothers reporting either fast breathing or difficult breathing as a sign of child illness needing treatment.	KPC	KPC surveyors	21%	65%	ARI
	30	% of mothers who report knowledge of at least 2 maternal danger signs[iv] during the postpartum period. [(1),3]	KPC	KPC surveyors	NA	50%	MNC
	31	% of respondents who identify consistent condom use, mutually monogamy, & abstaining from sex, as methods of reducing risk of HIV.[v]	FHI survey	FHI surveyors	10%	50%	HIV
	32	% of respondents who identify 2 or more signs/symptoms of STIs.	FHI survey	FHI surveyors	Data from FHI soon	25% incr.	HIV

Indicator sources: **1**: CS-13; **2**: Current DAP; **3**: KPC 2000+ CATCH / KPC 2000+; ( ) indicator modified.

[i] The actual incidence of WHO algorithm positive pneumonia is very difficult to measure accurately, and is likely to vary between sites. The Global Burden of Disease and Injury Series (Murray CJL, Lopez AD. Volume II, Global Health Statistics, Harvard University Press, 1996, Table 105) estimates an average

incidence of "lower respiratory infection" of 0.45 episodes per infant/child under five per year in developing countries. The actual incidence of algorithm positive pneumonia in children in Ethiopia is unknown. However, SC believes that an effective community-based case management program in rural Liben District, a very high mortality setting, should achieve rates of treatment of at least 0.2.

[ii] "Number of male/female respondents who used a condom the last time they had sex with a non-regular (i.e. non-spousal, non-cohabiting and non-commercial) partner, over number of male/female respondents who have had sex with at least one non-regular partner in the past 12 months."

[iii] Number of male/female respondents who used a condom every time they had sex with any non-regular (i.e. on-spousal, non-cohabiting and non-commercial) partner over the past 12 months, over number of male/female respondents who have had sex with at least one non-spousal, non-cohabiting and non-commercial partner in the past 12 months."

[iv] At least 2 of the following 3 signs: fever, excessive bleeding, smelly vaginal discharge (KPC 2000$^+$ postpartum care module).

[v] "Number of male/female respondents able to identify consistent condom use, mutually monogamy between HIV negative partners, and abstaining from sex as methods of reducing the risk of contracting HIV, in response to prompted questions over total number of male/female respondents surveyed."